

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-016578**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. 97

**FILED MAY 13 1963**

VS 300  
Rev. 4/59

1 0535

2 0150

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4 1

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9 181.0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Camden</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lebanon</u>		c. CITY OR TOWN <u>Camden</u>	
Length of stay in lb <u>5 Days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Wallace Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>R. Route 1</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>May</u> Last <u>Hanks</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7-1888</u>
9. AGE (last birthday) <u>75</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>29</u>	
11. IF UNDER 24 HR Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (City and state or country) <u>Old Linn Creek Mo</u>		12. NAME OF HUSBAND OR WIFE <u>Walter Hanks</u>	
13a. FATHER'S NAME <u>John W. Jefferies</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Bland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no</u>		17. INFORMANT <u>Argus Hanks</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NEUROCIRCULATORY COLLAPSE</u> DUE TO (b) <u>CARCINOMA OF URINARY BLADDER</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>48-50 Hours</u> <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY. Hour <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>CAMDENTON, MO.</u>		
21. I attended the deceased from <u>9-1-59</u> to <u>5-6-1963</u> and last saw her <u>alive</u> on <u>5-6-63</u> . Death occurred at <u>4:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert H. Reed</u> (Degree or title)		22b. ADDRESS <u>CAMDENTON, MO.</u>	
22c. DATE SIGNED <u>5-7-63</u>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 9th, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laughlin Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>CAMDEN COUNTY, MISSOURI</u>
24. FUNERAL DIRECTOR <u>Robert H. Reed</u>	25. DATE RECD. BY LOCAL REG. <u>5-8-1963</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Day</u>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address Camdenton Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

2620  
2-210

Permit not sealed - H.S.H.